Name/Title:_____

Agency:_____

Kansas Department of Health & Environment
Office of Local & Rural Health

Site Application
State Loan Repayment Program of Kansas

This application form is used to determine site eligibility for local participation in the State Loan Repayment Program of Kansas. If you need additional space to answer any of the questions, attach as many pages as needed: **type your name, title, and agency at the top of each page.**

Prior to completing the application, communities must agree to:

1. Assure that all clients will be provided primary care services regardless of the ability to pay.
2. Provide a $1 match for each $1 of federal money for the duration of the contract.

Criteria used to determine site eligibility include:

1. HPSA or State Medically Underserved designation.
2. Physician to population ratio.
3. Number of persons per square mile.
3. Significant risk factors which may prevail, such as high infant mortality rate, high poverty levels, high percent of the population over age 65.
4. Degree of community support.
5. Written plan to include care for all clients in need regardless of ability to pay.
6. Written assurance that Medicare assignment will be honored and Medicaid patients served.

Supporting documents should include:

1. Names of community members and agencies involved in determining the need for additional health professional(s) in the community, if appropriate.
2. Copy of written plan that includes care for all clients in need regardless of ability to pay and assurance that Medicare assignment will be honored and Medicaid patients served.
3. Copy of billing policies and a discounted fee schedule that reduces financial barriers to care.
4. Copy of posted notice regarding discount policy.
5. Copy of provider contract or signed employment agreement.
6. Letters of support for recruitment of additional health professional(s).

If your site is eligible to participate in this program and is successful in recruiting a qualified health professional, the State Loan Repayment Program of Kansas will provide up to the following maximum amounts according to type of provider recruited. Smaller amount may be requested.

	State Loan Repayment	**Local Match**	**Total**
Primary Care physician:	$52,500 (3 yr commitment)	$52,500 (3 yr commitment)	$105,000
Dentist:	$52,500 (3 yr commitment)	$52,500 (3 yr commitment)	$105,000
Mid-Level practitioner	$22,500 (3 yr commitment)	$22,500 (3 yr commitment)	$ 45,000

A local match must be guaranteed by the community.

Minimum contracting period is two years.

Questions concerning this application
should be addressed to the KDHE
Office of Local and Rural Health (785) 296-1200.

PLEASE NOTE:
State loan repayment awards are considered non-taxable income by the IRS for any amounts received on or after January 1, 2004.

Name/Title:_____

Agency:_____

Site Information *(Complete a separate application for each loan repayment candidate)*

1. Service Area

a. Identify Boundaries:_____

_____

_____

b. Population Centers included in this service area:_____

_____

c. Target population to be served:

Total Population: _____

Number of Medicaid Recipients: _____

Percent of population over age 65: _____

Percent of population un-insured: _____

d. Other community organizations, health agencies or providers involved in determining need:

_____

_____

_____

_____

2. Practice Information: Health professional position requested through state loan repayment program. Indicate profession and type of practice setting(s):

Health Profession	check one
Physician	
Dentist	
Physician Assistant	
Nurse practitioner	
Dental hygienist	
Clinical psychologist	
Clinical social worker	
Mental health counselor	
Licensed professional counselor	
Marriage and family therapist	

Primary Practice Setting Check as many as apply	
Hospital Privileges	
Solo Practice Site	
Group Practice	
New Group Practice	
Established Practice	
Public Agency	
Private Agency	

a. Name of medical director for mid-level, if applicable:_____

b. If a physician is requested, list other physicians currently practicing in the service area:

Name	Specialty
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name/Title:_____

Agency:_____

3. List any **indicators of unusually high need** in the service area, such as unemployment, cultural or language differences in the community, difficulty with primary care access for medicaid or medicare clients, etc:

_____

_____

_____

_____

_____

4. List the **proposed salary and benefits** for a new provider plus malpractice coverage, if provided by the community:

_____

_____

_____

5. Provide **financial disbursement plan** for State Loan Repayment funding and local match.

	Year One	Year Two	Year Three (if applicable)	Total award
State Program				
Local Match				
Total				

6. Describe the proposed **retention plan**:_____

_____

_____

_____

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7. Applicant information for recruiting site:

Name and title of person completing application:

Agency Facility: _____

Address_____

_____

Phone #: _____ Email Address:_____

Fax #: _____

_____ _____

Signature Date of Application

Return this application to:

Kansas Department of Health and Environment
State Loan Repayment Program of Kansas
1000 SW Jackson, Suite 340
Topeka, KS 66612-1365